STATE: Georgia

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

A. Ambulance Services

Payment for covered services shall not exceed the lower of:

(a) The provider's submitted charge; or

(b) The statewide maximum allowable rate in effect on the date of service.

The maximum allowable amount is derived from Medicare's maximum allowable reimbursement rates for non-hospital based ambulance services. The maximum rates are those supplied by the Medicare intermediary in May 1993, on the Medicare Part B Disclosure Fee Screen for non-hospital based ambulance services. The maximum allowable amount for waiting time is derived from an analysis of the usual and customary fees charged by providers throughout the state.

Emergency air ambulance providers will be reimbursed on a negotiated rate basis. Payment for covered services shall not exceed the lower of:

(a) The provider's submitted charge; or

(b) The amount estimated for the air ambulance service.

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B. Clinic Service

1. Family Planning Services

Pre-established rates are based on actual cost information submitted from the Division of Physical Health, Department of Human Resources, to the Department of Community Health. Reimbursement is provided at a flat rate for initial, annual, and follow-up visits. There is no retroactive settlement. Reimbursement rates are based on the lesser of actual reasonable costs of the limitations as set forth in 42 CFR 447.325.

2. Community Mental Health Rehabilitation Services

Effective July 1, 1999, the Department adopted statewide, fee-for-service, reimbursement rates for each procedure code in the Community Mental Health Program. Rates are calculated from the statewide median base year cost documented in providers cost reports. The Department may in subsequent years and subject to legislative appropriation, re-calculate the base year using updated cost report data, or adjust the original base year using a HCFA accepted inflation factor.

Rates for new procedures will be established based on estimated cost and expected utilization data. New procedure rates are also compared to other public sector fee-for-service rates and utilization from other southeastern states. Reimbursement rates will be lower than the limitations set forth in 42 CFR 447.325.

Community Mental Health Procedure Codes Effective July 1, 1999	Procedure Code Descriptions	Unit	Initial Authorization Units
Y3000	Diagnostic Assessment	15 Minutes	16
Y3021	Initial Screening and Referral	15 Minutes	1 hour
Y3001	Intensive Day Treatment	1 Hour	25
Y3003	Methadone Maintenance	Per Contact	Unlimited
Y3005	Ambulatory Detoxification	15 Minutes	60
Y3006	Nursing Assessment & Hlth Srvcs	15 Minutes	16

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Y3006	Nursing Assessment & Hlth Srvcs	15 Minutes	16
Procedure Codes	Procedure Code Descriptions	Unit	Initial Authorization Units
Y3007	Physician Assessment & Care	15 Minutes	12
Y3008	Physical Therapy	15 Minutes	12
Y3009	Speech & Hearing Therapy	15 Minutes	12
Y3010	Occupational Therapy	15 Minutes	12
Y3011	Activity Therapy	15 Minutes	360
Y3012	Medication Administration	Per Contact	12/30
Y3013	In-Clinic Crisis Management	15 Minutes	12
Y3027	Out-of-Clinic Crisis Management	15 Minutes	12
Y3014	Family Training/Counseling	15 Minutes	24
Y3015	Group Training/Counseling	15 Minutes	32
Y3016	Individual Training/Counseling	15 Minutes	24
Y3018	Child and Adolescent Day Treatment	1 Hour	225
Y3025	Child and Adolescent Day Support	1 Hour	450
Y3020	Specialized Adolescent Substance Abuse Day Treatment	1 Hour	225
Y3022	Adult Peer Supports	1 Hour	Unlimited
Y3023	Adult Day Supports	1 Hour	450
Y3024	Adult Day Treatment	1 Hour	150
Y3026	Substance Abuse Intensive Outpatient Services	1 Hour	225

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

3. Federally Qualified Health Centers (COMMUNITY HEALTH CENTERS SERVICES (CHCS)

Reimbursement is provided for "core" services at an all-inclusive interim rate per encounter. The interim rate per encounter will be based on the lesser of the current Rural Health Program cap or the center's most recent Department of Public Health's Bureau of Common Reporting Requirement (BCRR). Future interim rates for each center will be based on the cost report data submitted by the center at the end of each fiscal year (reporting period). This rate will be based on the center's total costs for covered services and patient encounters for the reporting period. Rate adjustments are made as deemed necessary by the Department. Payments will be subject to retroactive cost settlement and will not exceed the amount which would be reimbursed by applying the Medicare cost reimbursement principles in 42 CFR at 413. As a result of the cost settlement process, payments to FQHCs will be at 100% of reasonable cost for "core" services. Those FQHCs receiving Public Health Service (PHS) grant funds are required by PHS regulations to apply the cost reimbursement principles found in 45 CFR 74.171 (CMB Circular A-87) for governmental entities and in 45 CFR 74.174 (CMB Circular A-122) for non-profit entities.

FQHCs providing the ambulatory services listed below will be reimbursed using an interim rate based on existing fee for service payments, and will be governed by the Medicaid policies and procedures specific to each program. The amounts reimbursed for these services will be subject to cost settlement as described above. As a result of the cost settlement process, FQHCs will be paid reasonable costs for other ambulatory services. Other ambulatory services include but are not limited to:

a. Early and Periodic Screening, Diagnosis and Treatment services
b. Dental services;
c. Mental health clinic services;
d. Refractive services;
e. Pharmaceutical services; and
f. Podiatry services.

Effective for dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all Federally Qualified Health Center Services (FQHC) [Community Health Center Services (CHC)]. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care participants are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment.

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C. Dental Services

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) The dentist's actual charge for the service; or

(b) The statewide reimbursement rate in effect on the date of service.

(c) Effective with dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all oral and maxillofacial services evaluation and management procedure codes. Recipients affected by the co-payment are limited to adult recipients of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one, pregnant women, nursing home residents, and hospice care recipients are not required to pay this co-payment. Emergency services and Family Planning services received by Medicaid recipients do not require a co-payment.

Single examinations covered are those during office hours and after hours emergency exams.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

d. Prescribed Drugs

1. Medicaid pays for prescribed legend and non-legend drugs authorized under the program. Reimbursement for covered multiple source drugs shall not exceed the lowest of:

(a) The Federal mandated upper limit for certain multiple source drugs as established and published by HCFA plus a reasonable dispensing fee.
(b) The Georgia Maximum Allowable Cost (GMAC) as established by the state agency for certain additional multiple source drugs plus a reasonable dispensing fee.
(c) The Georgia Estimated Acquisition Cost (GEAC) for multiple source drugs plus a reasonable dispensing fee.
(d) The provider's usual and customary charge to the general public for the prescription.

Reimbursement for covered drugs other than multiple source drugs shall not exceed the lower of:

(a) The GEAC for all other drugs plus a reasonable dispensing fee as established in item 2 below.
(b) The provider's usual and customary charge to the general public for the prescription.

GEAC is defined as the average wholesale price (AWP) of the drug less a 10% discount for all drugs except Schedule II controlled substances. For Schedule II drugs GEAC is AWP as determined by a survey of Georgia wholesalers, which demonstrated no discounts are given for this category of drugs.

The Department defines usual and customary as the average reimbursement accepted by the pharmacy from other Third Party payers (including HMOs); or the average amount routinely offered to any segment of the general public. Donations or discounts provided to a charitable organization are not considered usual and customary charges.

2. The dispensing fee for profit and non-profit community pharmacies is based on periodic surveys of pharmacy operating costs including professional salaries and fees, overhead costs and reasonable profit. Between surveys the fee is reviewed by the Department in consultation with the Pharmacy Advisory Committee and the Governor's Office of Planning and Budget. When appropriate, the fee is adjusted based on an inflation factor. The current fee is $4.41 for profit pharmacies and $4.11 for non-profit pharmacies.

A. Exception: Effective July 1, 1996, the Department will encourage the use of multiple source drugs. The innovator brand of a multiple source drug is covered if medically necessary.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

3. No fee is allowed for physician dispensing of drugs.

4 Payment for special approved drugs as requested by the prescribing physician is determined as in 1. above.

5. Prescriptions supporting Medicaid claims must be initiated and recorded in accordance with State and Federal laws. The maximum quantity payable for a prescription or its refill will be a one (1) month supply.

6. Effective with date of service July 1, 1994, the Department will impose a fifty cent ($.50) co-payment on each prescription dispensed to a Medicaid recipient. Recipients under age twenty-one, pregnant women, nursing home residents, and hospice care recipients are not required to pay this co-payment. Emergency prescriptions prescribed for Medicaid recipients do not require a co-payment. Emergency services and family planning services are also exempt from the co-payment.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

E. Durable Medical Equipment Services

The maximum reimbursement for providers of medical equipment is limited to the lower of:

(a) the actual charges for the item; or

(b) the statewide rate in effect on the dates of service.

Reimbursement for delivery mileage is limited to 100 miles, one way.

Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all Durable Medical Equipment and a $1.00 co-payment for all Durable Medical Equipment Supplies and Rentals.

Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from a co-payment.

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

F. EPSDT SERVICES

Reimbursement to EPSDT screening providers is based on the lower of submitted charges or the state's maximum allowable based on reported actual costs for providing the services. Immunizations are reimbursed separately at established rates.

Medically necessary noninstitutional and institutional services which are not otherwise covered under the State Plan require prior approval and will be reimbursed under the respective program using that program's established reimbursement methodology as described on Supplement 1 to Attachment 4.19-B, Page 1.

G. HOME HEALTH SERVICES

The Department will reimburse each Home Health Agency a specific rate per visit for covered services. The specific rate per visit is the total of the agency's inflated base rate, any efficiency incentive applicable to the agency, and a supply rate. Base rates, efficiency incentives, and supply rates are subject to ceilings. Rates, incentives, and ceilings are determined as follows.

(a) Each agency's base rate is based on data contained in the Medicaid cost report for that agency's base period determined by the Department. An inflation percentage is applied to the base year data to trend the agency's base period cost per visit from the end of the base period through the end of the reimbursement period. The resulting inflated base period cost per visit is the agency's base rate. The inflation percentage, base period, and reimbursement period are set by the Department.

(b) Each agency is classified into one of the following categories: hospital-based, freestanding urban, and freestanding rural. For each category, the 85th percentile of inflated base period cost per visit is determined. This amount is the base rate ceiling for agencies in the category.

(c) An efficiency incentive may be added to the base rate for an agency as follows:

If an agency's base rate is less than or equal to the base rate ceiling in the agency's category, the difference between the base rate and the ceiling is multiplied by 20%, and the product (not to exceed $1.76) is added to the base rate. The resulting total shall not exceed the base rate ceiling for the agency's category.

(d) The supply cost per visit for each agency is based on data contained in the Medicaid cost report for the agency's base period. An inflation percentage is added to reported data to trend the agency's supply cost per visit from the end of the base period through the end of the reimbursement period. The inflation percentage, base period, and reimbursement period for supply costs are set by the Department. Inflated base period supply costs per visit for each agency are arrayed on a statewide basis and the 85th percentile cost from that array is the supply rate. The supply rate is added to each agency's base rate in addition to any applicable efficiency incentive.

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

G. HOME HEALTH SERVICES

The Department will reimburse each Home Health Agency a specific rate per visit for covered services. The specific rate per visit is the total of the agency's inflated base rate, any efficiency incentive applicable to the agency, and a supply rate. Base rates, efficiency incentives, and supply rates are subject to ceilings. Rates, incentives, and ceilings are determined as follows:

(a) Each agency's base rate is calculated using data contained in the as-filed or audited Medicaid cost report for that agency's base period. An inflation percentage is applied to base period date and the resulting inflated base period cost per visit is the agency's base rate. The inflation percentage and base period are set by the Department.

(b) Each agency is classified into one of the following categories; hospital-based, freestanding urban, and freestanding rural. For each category the 75th percentile of inflated base period cost per visit is determined. This amount is the base rate ceiling for agencies in the category.

(c) An efficiency incentive may be added to the base rate for an agency as follows:

If an agency's base rate is less than or equal to the base rate ceiling in the agency's category, the difference between the base rate and the ceiling is multiplied by 20%, and the product (not to exceed $1.76) is added to the base rate. The total of base rate plus incentive shall not exceed the base rate ceiling for the agency's category.

(d) The supply cost per visit for each agency is based on data contained in the as-filed or audited Medicaid cost report for the agency's base period. An inflation percentage is applied to base-period data to determine each agency's inflated supply cost per visit. The inflation percentage and base period for supply costs are set by the Department. Inflated base period supply costs per visit for each agency are arrayed on a statewide basis and the 75th percentile cost from that array is the supply rate. The supply rate is added to each agency's base rate plus any applicable efficiency incentive.

(e) The reimbursement rate for each freestanding agency shall not exceed the base rate ceiling for that agency's category plus the supply rate. The reimbursement rate for each hospital-based agency will be calculated as noted in paragraphs (a) through (d), and shall not exceed the maximum rate noted in paragraph (f) below.

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